

## MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-009469

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 2099

STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUB

AMENDED

VS 300  
Rev. 4/59

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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <b>FILED MAR 8 1963</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis, Missouri.</b>		c. CITY OR TOWN <b>St. Louis</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>2 North Euclid Avenue.,</b>		d. STREET ADDRESS (If outside, give location) <b>4961 Laclede Avenue.,</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Harold Stubblefield</b>		4. DATE OF DEATH Month Day Year <b>February 22, 1963</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>1/13/1895</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Lease-Man</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>St. Louis Outdoor Adv.</b>	
11a. FATHER'S NAME <b>William H. Stubblefield</b>		11b. MOTHER'S MAIDEN NAME <b>Mary L. Shumate</b>	
12a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of war) <b>Yes</b>		12b. SOCIAL SECURITY NO. <b>W.W. 1</b>	
13a. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b>		13b. NAME OF HUSBAND OR WIFE <b>None</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Arteriosclerotic Heart Disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs</b>	
DUE TO (c) <b>4200</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21. I attended the deceased from <b>1/4/60</b> to <b>2/22/63</b> and last saw him alive on <b>1/10/63</b>		21. CITY, TOWN, OR LOCATION COUNTY STATE	
Death occurred at <b>3 PM</b> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>John B. Shapleigh M.D.</b>		22b. ADDRESS <b>3720 Washington St. Louis</b>	
22c. DATE SIGNED <b>2/25/63</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>2/25/63</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Valhalla Cemetery</b>	
23d. LOCATION (City, town, or county) <b>St. Louis County, Missouri.</b>			
24. FUNERAL DIRECTOR <b>Albert H. Hoppe, Inc., 4700 Washington Blvd.</b>		25. DATE RECD. BY LOCAL REG. <b>FEB 25 1963</b>	
26. REGISTRAR'S SIGNATURE <b>Loan Smith, M.D.</b>			

USE BLACK INK  
OR  
TYPEWRITER RIBBON

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**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed

*Melvin L. Kemper*

Licensed Embalmer No. 4052

P. O. Address 4911 Washington

St. Louis, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.